The PREVENTION CONNECTION
NEWSLETTER

The Safe Bridge and the Tightrope

By Peg Shea, LCSW, LAC, Executive Director, Western Montana Addiction Services

Service providers who treat adolescent substance abusers are challenged to develop a treatment program that on one hand encourages and promotes healthy choices, while on the other is not too prescriptive, too authoritarian or too parental. Developmentally, teens are transitioning away from their parents and aligning with peers, but they remain in need of adult guidance and support as they journey toward self identity. Treatment professionals need to assume the role of nonjudgmental guide, yet still hold up expectations, provide rules to abide by and set consequences. It's like walking a tight rope, but when the process succeeds, the treatment provider becomes a safe bridge for teens who are confused and confusing, angry yet afraid, independent yet needy, all knowing but lost.

It isn't just teens who need help during this difficult transition. Their parents and/or caregivers need understanding and support, as well as acknowledgement for the gargantuan efforts they are making and have made. It is essential to take a nonjudgmental approach that does not "shame" the parents or make them feel as if they have done something wrong. Oftentimes, the provider walks a tightrope here as well. A triangle forms and both sides want the provider on their side. The bottom line is that both the teenager and the parent need a safe bridge and understanding, information and support. Parents need to know and respect the physical, psychological and social pressures and processes operating within the teenager. Parents need to be given a lot of support and encouragement as they struggle through years that are confusing and challenging at best, and more difficult yet when coupled with substance abuse. Providers must understand the stress and anger and fear parents are experiencing, provide information about what is changing, teach skills and strategies on communicating and negotiating with teens, provide support when the new skills or plans don't work, develop opportunities for families to practice, learn and grow, and offer teens food and fun, fun and food, followed by more food and fun. It's a tall order.

Critical information about the addictive process is standard education in treatment, but it is imperative to inform parents and teens about the developmental processes occurring during the teen years. Much has been written about the physical, sexual and hormonal changes of adolescence. The emotional, psychological and social pressures and demands for today's youth are far different than they were in years past, partially due to the tremendous impact of the information age and a constant barrage of media filled with sex, violence and quick fixes. When a teenager shouts, "*You don't understand . . . you don't know what I'm going through!*" she's right. The world has changed, social influences are different, and avenues for rebellion are more varied and far more deadly. Societal messages are also more inconsistent and confusing than ever before.

Changes

We can see some of the complex physical changes occurring in an adolescent. What we can't see is that the brain is still developing. We now know that significant growth in the brain is occurring throughout adolescence, and that this affects abilities and behaviors. Complex and continued growth is taking place in the cerebral cortex and frontal lobes (the so-called police-

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The Vicki Column

We have focused on different segments of the prevention continuum for the past few issues—on recognizing and addressing abuse and addiction issues once they arise. These are difficult topics, but if you've pulled one thing from these issues, we hope it is the conviction that prevention is the optimum choice.

Tobacco is the gateway drug for most kids. The younger a youth starts smoking tobacco, the greater the chance that s/he will graduate to alcohol, then drugs. Alcohol remains the drug of choice among Montana youth, and as such, presents the most clear and present danger. At the same time, a cornucopia of other drugs are readily available and dangerously destructive. There is nothing pretty about what drugs and alcohol do to young people. They mark the path into a very dark forest fraught with danger. Many youth who enter there never manage to find their way out.

Research demonstrates that if children and youth have certain protective factors in their lives, they are less likely to engage in risk behaviors, including the use of alcohol, tobacco and other drugs. Parents who talk to their children about drugs nearly double the chance that their children won't use them. Children who have mentors are less likely to skip school. They demonstrate improved academic performance and develop better relationships with peers and family members. Studies also show that young people who are exposed to anti-drug advertising say the exposure deters their use of drugs.

There are things each of us can do to make a difference in our communities and for our youth. Treatment works, there's no question about that. There's also no question that we need to focus our attention on providing the very best treatment possible for those who need it. But prevention works, too. Prevention is extremely cost effective. It adds value and quality to lives, communities and families. Given the choice, I'll take prevention over treatment for my kids any day.

Vicki

Substance *Abuse* or *Dependence*?

A person is defined with *abuse* of a substance if he or she is not dependent on that substance and reports one or more of the following symptoms in the past year.

1. Recurrent use resulting in failure to fulfill major obligations at work, school, or home;
2. Recurrent use in situations in which it is physically hazardous (e.g., driving an automobile);
3. Recurrent substance-related legal problems; and
4. Continued use despite having persistent or recurrent social or interpersonal problems.

A person is defined as being *dependent* on a substance if he or she reports three or more of the following symptoms in the past year:

1. Tolerance—less effect with the same amount (needing more to become intoxicated);
2. Withdrawal characteristic to the type of drug;
3. Using more or for longer periods than intended;
4. Desire—or unsuccessful efforts—to cut down or control substance use;
5. Considerable time spent in obtaining or using the substance or recovering from its effects;
6. Important social, work or recreational activities given up or reduced because of use; and
7. Continued use despite knowledge of problems caused or aggravated by use.

Source: DSM-IV Diagnosis: *http://www.samhsa.gov/oas/2k2/dependence/dependence.pdf*

The Safe Bridge

Continued from cover

man or chief executive of the brain), which control reason, judgment and motivation. The frontal lobe provides the abilities to plan ahead, resist impulses, do the right things—in essence—to be "grown-up." And yet researchers increasingly believe that this part of the brain is not fully developed until the individual is well past twenty. As one child researcher stated, "development is progressive inhibition." If judgment seems to be lacking, it may be because teen brains have not fully developed. Incomplete development coupled with wild hormonal shifts means that teens have passion and drive, but just fledgling ability to control those impulses. It's like careening down a mountain pass, full speed ahead without any brakes.

Oftentimes, the child transforms into someone who *looks* like an adult almost overnight. Along with the new look, parents expect adult behavior and believe their teens can handle making the right choices. Parents often want to believe in the teenager's plea "to be treated like an adult." Deferring can be the prelude to disaster. Again and again, hope, trust and belief are dashed as failure occurs. Pretty soon the "trust bank" is empty. Parents revert to trying to exercise total control by treating the teen as if s/he is acting - *two*. But that approach doesn't work either. Parents are simultaneously overwhelmed and confused. Family time begins to feel chaotic.

Parents and treatment providers are on the tightrope, often without a safety net—offering respect and encouraging teenagers' need for autonomy, but sometimes stepping in and offering a road map by talking through possibilities and options. In other words, caring adults need to serve as the teenager's "frontal cortex," acting as auxiliary problem solvers.

Teens are not able to connect all the information they receive. They may not be able to figure *why* they feel the way they do. They might not have an answer when you ask, "*What on earth possessed you to do that?*" They can't figure out why it's a problem for you when they go from playing dolls by the hour to wanting to stay out until all hours. Their actions outrace their judgement and they process social emotions like anger and pain unpredictably. Sometimes it seems as if they can't even respond to the English language anymore, or that they're lost in boredom or fantasy. As teens swing from one level of capacity to another, parents become frustrated and angry.

Now add chemicals—like alcohol or other drugs—to that developing and sensitive brain and you may as well throw kerosene on the fire. Suddenly you have a teenager who is even *more* unpredictable and a family that is even more frustrated. During the time the teenage brain is reconfiguring itself, it remains highly susceptible to deep wounds and long-lasting damage. Some neuroscientists warn that adolescence may be one of the worst times to expose a brain to drugs and alcohol—or even to a steady dose of violent video games. A recent study found that teenagers who drank excessively (two drinks a day for two years) consistently recalled ten percent less on memory tests than their non-drinking peers—a rate worse than that of adults who have a history of alcoholism. The bottom line is that the teenage brain is more sensitive to alcohol or other neurotoxins than at any other time, except perhaps, during gestation.

Volumes have been written and discussed about the separation and identity formation phases teens pass through on their way to adulthood. A review of the last 50 years of literature on adolescent developmental suggests that these processes—and the teens themselves—have not changed much, beyond the earlier onset of puberty. What has changed is twofold: parents believe that kids are able to always make good decisions and act like adults, because, after all, they *look* like adults. This is coupled with the fact that parents are busier than ever before, and it can be *way easier* to let the teenager have his/her own way. The other change is ready access to a profound outside influence that includes a world of unedited and unscreened information.

Every day brings new choices, new decisions, new changes to agonize about – for teens, their parents and providers. Walking the tightrope is tough and a missed step can mean a long, disastrous fall. But if you stick it out, provide the safe bridge to the other side of the dangerous chasm called adolescence, there's no question that the rewards are worth every agonizing moment.

Peg Shea, M.S.S.W., L.C.S.W., C.C.D.C., is the Executive Director of Western Montana Addiction Services in Missoula, Montana. Turning Point can be reached at (406) 532-9800.

Ten Commandments for Parenting Your Teen

1. *Unto Thine Own Child: Be Cool, Not the Fool*
2. *Thou Shalt Listen Even as Thine Own Child Shouts*
3. *Thou Shalt Not Shout: Speak Thou Wisely*
4. *Thou Shalt Add 15 Minutes to Every Interaction Involving Thy Teen*
5. *Thou Shalt Vanguish Thy Foolish Pride*
6. *Thou Shalt Not Kill (Thou May Entertain Thoughts of Killing, But…)*
7. *Thou Shalt Apologize at Every Opportunity*
8. *Thou Shalt Honor Thy Child's Identity (Even Though It Maketh You Ill)*
9. *To Thine Own Self Be True*
10. *Know Thou, This Too Shall Pass*

Developed by Michael Bradley, Ed. D.

Over the last ten years, among teens admitted to out-patient treatment at Turning Point:

— 25 percent have been "throw away" kids;

— 25 percent of parents have believed it's the teen's problem; and

— 50 percent of parents got involved.

Notes From the Edge

Reflections

By Henry Real Bird, Public Relations Director, Thunder Child Treatment Center

I am the feeling morning after yesterday,
just before the sun is a little beyond nothing…
on this side of everything,
dreaming of a feeling in a dream.
This is where it is tough thinking of love,
when there is no love to go around.
I am tired and I am lonesome
for the life I never had.

These words and feelings are from
the bottom of life's pentacle,
where death was welcomed.

The endless circle of human life has been walking through the four different grounds upon our Sacred Mother Earth since the beginning of time known to man, and we go through sunrises, sunsets, crescent moons and many winters. Life is made of the water, ground and wind. Wherever *Moves All of the Time* (water) goes, there is life. The ground is our sacred mother, for we are from the water, ground and wind.

There was no life when the water and the ground were mixed, but then, when Old Man Coyote breathed upon this mud being, the red fox jumped out to watch the ground. All the four-legged, the winged, snakes, water beings and human beings are from the water, ground and wind.

Alcohol, fire water, water that is bad came up the Big River, the Missouri River, for the Ones With a Breach Cloth at the head waters, the still waters of the Big River, the Missouri, Yellow Stone, Big Horn, Tongue, Powder, Platte, Canadian, Arkansas and Rio Grand rivers. But before this insanity arrived in the sunrise, there was peace, tranquility and contentment in the wind. From the first taste of alcohol, violence erupted in the mountains and plains to where now personal bottoms are reached daily throughout Indian Country. Likewise for non-Indians, for the diseases of alcoholism and drug addiction know no race barriers.

We are given wishful thought and prayer to become real human beings. This is the door that awaits the survivors of this fatal disease of alcoholism. Thunder Child Treatment Center, along the banks of the Tongue River, in the shadow of the Big Horn Mountains, between the Seven Stars of the Big Dipper and the Mountain With Something Beyond is the perfect place to meet your *live shadow* (soul).

Prayed the woman in the silence of the hills as she offered the water to the Sun Dancers in the Sun Dance Lodge when all shadows were as short as they were to be for the day. *"Maker of All Things, a while ago the drumbeat roar trembled through me like many buffalo hoof beats, and my heart beat one with my mother Earth. These women and men have opened up their hearts to you. They have let their tears fall upon you, Mother Earth, to soften your heart so you would make their prayers come true. Maker, watch this water, and when we drink of this water, let us be lucky, let our hearts be good, let us be free of illness, let us eat the best of meat, let us use sleep that is good to see a dream that is good, let us use talk that is good and help us stay upon our sacred Mother Earth for many winters to come . . . to get enough of our loved ones, the people of our blood and the people who talk good to us. They say that there are a lot of nice things in the wind. Let us use the good things in our lives."*

The Teenage Brain: *A Work in Progress*

New imaging studies are revealing—for the first time—patterns of brain development that extend into the teenage years. Although scientists don't know yet what accounts for the changes, they may parallel a pruning process that appears to follow the principle of "use-it-or-lose-it." Studies of developing visual systems suggest that neural connections of animals that get exercised are retained. Those that don't are lost. Although both genes and environment play major roles in shaping early brain development, science still has much to learn about the relative influence of experience versus genes on the maturation of the brain. It is not yet clear whether experience creates new neurons and synapses or establishes transitory functional changes. Nonetheless, the research provides a compelling reason for protecting and nurturing teens' brains as works in progress.

Newfound appreciation of the dynamic nature of the teen brain is emerging from MRI (Magnetic Resonance Imaging) studies used to scan a child's brain every two years. Individual brains differ enough that only broad generalizations can be made from comparisons of different individuals at different ages. Following the same brains throughout the maturation process allows scientists a much better view into developmental changes. In the first longitudinal study of 145 children and adolescents (1999), Dr. Judith Rapoport and her colleagues at the National Institute of Mental Heath were surprised to discover a second wave of overproduction of gray matter just prior to puberty. This may be related to the influence of surging sex hormones. The thickening peaks at around age 11 in girls, 12 in boys, after which the gray matter actually thins.

Prior to this study, research had shown that the brain overproduced gray matter for a brief period in early development—in the womb and for approximately the first 18 months of life—after which it underwent one bout of pruning. Researchers are now confronted with structural changes that occur much later in adolescence. Teens' gray matter waxes and wanes in different functional brain areas at different times in development. For example, the gray matter growth spurt just prior to puberty predominates in the frontal lobe, the seat of "executive functioning"—planning, impulse control and reasoning. In teens affected by a rare, childhood onset form of schizophrenia that impairs these functions, the MRI scans revealed four times as much gray matter loss in the frontal lobe than normally occurs. Unlike gray matter, the brain's white matter—wire-like fibers that establish connections between brain regions—thickens from birth. A layer of insulation called *myelin* progressively envelops nerve fibers, making them more efficient and improving their conductivity.

UCLA's Dr. Arthur Toga and his colleagues turned the NIMH team's MRI scan data into time-lapse animations of children's brains morphing as they grow up. Researchers report a wave of white matter growth beginning at the front of the brain in early childhood. This moves back, then subsides after puberty. Striking growth spurts occurred in the areas connecting brain regions specialized for language and spatial relations in children aged 6–13. This growth drops off sharply after age 12, coinciding with the end of a critical period for learning languages.

While this work suggests brain white matter development that flows from front to back, various studies suggest that gray matter maturation flows in the *opposite* direction, with the frontal lobes not fully maturing until young adulthood. UCLA researchers compared MRI scans of young adults aged 23-30 with those of teens aged 12-16. They looked for signs of myelin within the gray matter, which would imply more mature, efficient connections. The largest differences between the age groups occurred in the frontal lobe.

Another series of MRI studies suggests that teens process emotions differently than adults. Using functional MRI (fMRI), a team led by Dr. Deborah Yurgelun-Todd at Harvard's McLean Hospital scanned subjects' brain activity while they identified emotions on pictures of faces displayed on a computer screen. Young teens, who characteristically perform poorly on the task, activated the amygdala, which mediates fear and other "gut" reactions. As people age, brain activity during this task shifts to the frontal lobe, leading to more reasoned perceptions and improved performance. These functional changes parallel structural changes in temporal lobe white matter.

While these studies demonstrate remarkable change in the brain during the teen years, they also demonstrate what every parent can confirm: the teenage brain is a very complicated and dynamic arena, one not easily understood.

Source: NIH Publication No. 01-4929 *(http://hstat.nlm.nih.gov/hq/Hquest/fws/T/db/local.sgen.sgcrp.mhch/screen/Browse/s/45509/action/GetText/linek/0)*

For more information:
National Institute of Mental Health (NIMH)
Web site: http://www.nimh.nih.gov

PNA Data Bites

On the 2002 Prevention Needs Assessment Survey, students who reported their age at the first regular use of alcohol as 14 or younger:

—18.5% of 8th graders;

—18.8% of 10th graders; and

—14.2% of 12th graders

Age 15 or younger at first regular alcohol use:

—18.8% of 8th graders;

—36.1% of 10th graders; and

—27.7% of 12th graders.

Intervention

By Kay Flinn, Licensed Addictions Counselor

So often alcohol and other addictions are protected by a conspiracy of silence. These allow the denial and delusion accompanying addiction to grow and become more harmful.

Just what *is* intervention? I'll start there because I believe there are some harmful misconceptions about the process of intervention in reference to addiction. Basically, intervention is anything that *interferes in the progression* of addiction or destructive mental disorders. Using this simple description, a medical, legal or personal crisis, job loss or compassionate confrontation could act as an intervening force. The latter—compassionate confrontation—is *not* something we do *to* the addicted person. Rather it is the safe and caring way for those concerned and harmfully impacted by the addict's use to break the "no talk" rule and offer help. It is *not* an angry attack.

I had the good fortune to train with Vernon E. Johnson at the Johnson Institute twenty-some years ago. He is identified as the developer of the Concerned Persons style of confrontation. Since that time, I have helped facilitate and conduct close to 200 interventions. The number of persons who have *not* gone into treatment from these is less than twenty. Not all of those who went into treatment recovered, but they learned that there is a way out of the problem. At the same time, friends, families and employers did what they could to help. At the very least, this kind of confrontation makes using far more uncomfortable for the addict.

All addiction is eventually terminal. Alcohol and the problems related to it comprise the third leading cause of death in the United States. In our own state, drunk driving deaths are way up there. Unchecked alcoholism will harmfully impact at least five lives beyond the chemically dependent person's, but there is also an ever-widening and positive "ripple effect" that comes from intervention.

The focus in the actual intervention (and the prepared statements of group participants) is the behavior and performance of the addicted person when s/he is under the influence. It is my belief, backed by observation, that very *specific, descriptive* statements are most effective in breaking through the denial and delusion. So rather than a general, "I think your drinking is causing problems," a group member might state, "I care a great deal about you. When you passed out from drinking at my birthday party, I felt hurt and angry."

In my opinion, families and groups (personal or professional) should not attempt an intervention without professional assistance. A *trained* interventionist will implement the following steps.

1. Respond to the initial inquiry about what intervention is/is not, stressing absolute confidentiality with all parties concerned.
2. Provide sound alcohol/drug education (e.g., what addiction is and is not) for the group, which may blast some stereotypes.
3. Collect data from the group.
4. Provide "how to" information for the group on writing statements that include data and particulars.
5. Identify the real goal—leading the addict to in- or out-patient treatment.
6. Arrange for treatment, insurance benefits, transportation, an in-patient bed, employment, child care and addressing other obstacles.

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There are four basic parts to the overall process of intervention:

- ***— Identification of the addiction;***
- ***— Identification of the key concerned persons;***
- ***— Education and training for those willing to be involved; and***
- ***— Actual intervention—the compassionate confrontation by concerned persons who describe the "bottom" the addict has hit. This means "raising the bottom" enough to be seen and heard, then penetrating the ever-thickening wall of denial and delusion.***

AL-ANON / ALATEEN

Hope and help for families and friends of alcoholics

Al-Anon and Alateen help families and friends of alcoholics recover from the effects of living with the problem drinking of a relative or friend. The program is adapted from Alcoholics Anonymous and based on the 12 Steps, 12 Traditions and 12 Concepts of Service. The only requirement for membership is having a relative or friend with alcoholism.

Visit www.al-anon.alateen.org/

20 Questions

Are you troubled by someone else's drinking? Here's a quiz to help you decide whether you need AlAnon.

http://www.al-anon.alateen.org/quiz.html

Intervention

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7. Prepare statements by group members, always beginning with a statement of love, care or concern. Select a spokesperson.
8. Rehearse all participants in a role play of the intervention—discuss and plan when and where the confrontation will occur.
9. Perform the actual intervention.

In our culture, we often view pain as bad in and of itself. While none of us likes pain, it can be a valuable signal that something is wrong. Both emotional and physical pain can be red flags that need to be heeded and dealt with from a causal perspective.

The concerned persons' intervention utilizes the pain of those involved. The articulation of their pain is in turn painful for the alcoholic to hear. There can be an either/or consequence, such as "get help or divorce is imminent" or "your job and position here are in jeopardy." These cannot be idle threats: the person involved must be prepared to act. The projected consequences can act as a lever to move the addicted person to help. This, of course, involves risk. *What if s/he becomes angry? Leaves? Won't respond to or accept treatment?* The risk of not intervening is much higher. Every day the addict uses s/he could kill or harm themselves or others—physically or emotionally. In this light, the risk of anger or the refusal to get help seems one well worth taking.

Kay Flinn, B.A., LAC, has worked in the addiction field for 29 years. She has practiced rural outreach, served as training manager for Montana's Addictive Diseases Unit, and has served as a consultant to the State Bar on intervention with impaired attorneys and judges. She maintains a private practice—Counseling and Consulting Services—in Helena.

What's for dinner?

In a survey of 12 to 17 year olds, the number who have regular family dinners drops by 50 percent as their substance abuse risk increases sevenfold.

Source: National Center on Addiction and Substance Abuse at Columbia University: http://www.casacolumbia.org/publications1456/publications_show.htm?doc_id=192313

Meth Free Montana

By Sherrie Downing, Editor

The general consensus is that we're not going to arrest our way out of this.

The Montana Division of Criminal Investigation sponsored a *Meth Free Montana Conference* in October, bringing Drug Endangered Children and anti-meth speakers who have "been there and done that" together with people battling this drug in their own communities. The intent of the conference, which was held in Great Falls, was to inspire and motivate attendees to begin taking control of the meth situation in their local jurisdictions.

Methamphetamine use, production and distribution appear to be growing throughout Montana, as evidenced by the jump from the 16 meth labs discovered in 1999 to the 122 labs discovered in 2002. Throughout Montana, meth use has been linked to a wide range of other crimes, from partner assaults and forgeries to robberies, internet crime and drive-by shootings. It's affordable, available, suppresses appetite, elevates mood and it enhances energy and libido. During a binge, it also depletes the brain of dopamine and damages the neurotransmitters, likely beyond repair. The darkness accompanying any short term "lifts" cannot be overstated.

Kathryn Wells, MD, FAAP, with the Colorado Alliance for Drug Endangered Children, spoke about the medical aspects of methamphetamine use. She stated that recent animal studies have shown that a single high dose of meth can result in significant damage to the nerve terminals in the dopamine-containing areas of the brain. Further studies reveal that the damage to nerve cells is long-term, creating effects similar to those caused by stroke or Alzheimer's Disease. Long term effects—beyond addiction—include behavioral changes, cognitive impairment, psychosis, violence and medical complications ranging from cardiovascular and central nervous system impairments to extreme dental decay. Perhaps even more devastating is that meth-using parents

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Meth use has been equated with giving up everything important in life to pursue a demon.

For more information, visit Meth Free Montana (http://www.methfreemt.org/).

MONTANA
Department of Public Health & Human Services

AMDD Successes: SFY 2003

— Through AMDD (among others), 1,363 youth under age 21 and 862 women with dependent children received chemical dependency services in SFY 2003;

— When surveyed, 92 percent of Montana Chemical Dependency Center (MCDC) clients rated their satisfaction with the services they'd received as excellent or above average;

— 81 percent of those scheduled for services at MCDC were admitted; and

— 92.75 percent of the referrals made to MCDC were appropriate (e.g., patients met the stated criteria for admittance).

For more information visit the AMDD website at: www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/addictive_mental_disorders.htm

Meth Free Montana

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become so focused on their drug use that they cannot meet even the most basic needs of their children. Dr. Wells illustrated this by stating that nearly 70 percent of the child abuse cases in areas of heavy methamphetamine use are believed to be related to meth use.

"Every case is the same," stated Sue Webber-Brown, a District Attorney Investigator from Butte County, California. Ms. Webber-Brown would know. She has been on special assignment as a detective with the Interagency Narcotics Task Force for the past 12 years. She is responsible for developing the successful "Drug Endangered Children" (DEC) Program, the first of its kind in the nation. Ms. Webber-Brown stated simply that this drug is so addictive that soon it is all that matters to the addict. Before DEC, kids were ignored as victims. Evidence of child endangerment was not collected despite their presence in highly-volatile, dangerous and toxic environments. Now DEC Teams come together around these children, and include law enforcement personnel, an assigned prosecutor from the District Attorney's Office, a Child Protective Services worker, health services, code enforcement and medical professionals.

Many who spoke at the conference believe meth consumption to be at epidemic levels in Montana. None of this will come as a surprise to those who read the *Methamphetamine in Montana* issue of the *Prevention Connection*, published in Summer 2003. This conference did, however, underline the urgency of the need for communities to focus on this issue. Prison isn't working: instead we're seeing technology transfer there, leading to the release of bigger, better meth cooks.

Bill Mercer, a U.S. Attorney in Montana and Chair of the Montana Board of Crime Control, stated that the attack has to be mounted in three tiers: education, treatment and enforcement. We have to work toward demand reduction while ensuring effective enforcement with swift, sure sanctions and appropriate social service response. We must learn to be proactive rather than reactive, to adopt a team concept that is multi-disciplinary, enacted in the spirit of cooperation, and which includes information sharing and coordination.

This is a huge problem and it is going to take every one of us to beat it, no matter what our skills. When children are taken from meth homes, they need comfort bags that include clean clothing, a blanket, something to read, something to hold. They will need people like Big Bothers and Big Sisters and Foster Grandparent volunteers to read to them, talk to them, and to teach them hope. Educators need to understand and remain vigilant for the signs of abuse and neglect that accompany these children like a shadow. Neighbors and service people need to keep their eyes open and know what to watch for. And there must be opportunity for adequate treatment in settings—like Montana's Mothers and Children's Homes—that provide the right treatment in the right dosage for the right amount of time.

It's a tall order. We commend the Division of Criminal Investigation, Governor Martz, Attorney General Mike McGrath, Mike Batista, Mike Cooney, Bill Mercer, Senator Trudy Schmidt, Representative John Parker, Holly Beall, Fred Cowie and a host of others for starting this conversation on a statewide level and for keeping it going.

Congratulations!

Roland M. Mena, former Bureau Chief of the Chemical Dependency Bureau, became the Executive Director of the Montana Board of Crime Control in October. Thanks to his creative leadership, he's made a tremendous difference for Montana in his position as Chief of the Chemical Dependency Bureau. Roland has also provided wonderful support for the Prevention Resource Center and the *Prevention Connection.* We'd like to express our appreciation and congratulations as he takes this next step. We know he'll continue to make Montana a better place to live.

—Vicki Turner, Director, PRC
and Sherrie Downing, Editor

The Costs of Substance Abuse

Shoveling Up: the Impact of Substance Abuse on State Budgets is the result of three years of research by the National Center on Addiction and Substance Abuse at Columbia University. The survey was the most extensive and sophisticated ever conducted in this field. State budgets for 1998 were evaluated to determine the impact of substance abuse and addiction in 16 budget categories including health, social service, criminal justice, education, mental health, developmental disability and others.

On average, of every $100 Montana spent on substance abuse in 1998, $96.75 was spent on the burden to public programs, $2.82 was spent on prevention, treatment and research. and $0.43 was spent on regulation and compliance.

The Costs of Substance Abuse: the impact on Montana's State Programs* Spending related to substance abuse			
State Budget**	**$ Impact on State Budget**	**As % of 1998 Cost**	**Per Capita Cost**
	$247,503,700	**14.9%**	**$281.67**
Regulation/Compliance	**$1,100,000**		**$1.25**
Prevention, Treatment and Research	**$7,214,000**		**$8.21**
Totals	**$255,817,700**	**15.4%**	**$291.13**
Source: *Shoveling Up: the Impact of Substance Abuse on State Budgets http://www.casacolumbia.org/usr_doc/47299a.pdf			
**** Includes impacts to justice, education, health, child/family assistance, mental health, developmental disabilities, public safety and state workforce.**			

The cost benefit ratio

The success rates of good treatment programs far exceed those of treatments for diseases including cancer and other chronic, progressive illnesses. Tremendous public savings are generated by an investment in treatment. The cost per client treated in Montana during FY 2002 was $1,767. The savings most often cited by national studies is around $7 saved for every $1 spent on treatment. Using this figure, it is possible to estimate that $12,369 is saved for each client treated—or approximately $69.4 million in FY 2002 alone. (AMDD, 2002)

Who needs treatment?

According the *Addictive and Mental Disorders Annual Report* for 2002:

— In 2001, as many as 53,107 adult Montanans (age 18+) were in need of treatment services.

— Among Montanans of *all* ages, 60,826 were in need of treatment.

— On average in FY 2002:

- Montana's publicly funded treatment system served 1,162 clients/month on an out-patient basis, and 223 clients/month as intensive out-patients;
- 5,611 Montanans—or 9 percent of those needing services—received treatment; and
- 49.3 percent of those served were first-time admissions.

State Fiscal Year 2002		
Funding Source	**Services Provided**	**Expenditures**
Medicaid	**Youth & Adult Treatment**	**$ 906,512**
Substance Abuse Prevention & Treatment (SAPT) Block Grant	**Youth and Adult Treatment**	**$ 3,979,075**
	Prevention	**$ 1,021,097**
	Synar Youth Tobacco Access	**$ 101,720**
	Division Administration	**$ 483,159**
Community Incentive Grant	**Science-based Community & Youth Prevention**	**$ 2,432,640**

Sources Cited:

Shoveling Up: the Impact of Substance Abuse on State Budgets. National Center on Addiction and Substance Abuse; Columbia University. 2001. *http://www.casacolumbia.org/usr_doc/47299a.pdf*

AMDD 2002 Annual Report:

http://www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/additional/amdd_2002_annual_report.pdf

Treating Teens: *A Guide to Adolescent Drug Programs*

BOOK REVIEW

Teenagers are not just younger versions of adults and they can't be treated as such. To be effective, drug treatment programs for teens have to address adolescent development and family issues, which play enormous roles in the lives of young people and have an impact on their drug use and recovery.

– Dr. Robert Millman,
Chair of the Treating Teens Advisory Panel.

Drug Strategies is a non-profit research institute that promotes more effective approaches to the nation's drug problems and supports initiatives to reduce the demand for drugs through prevention, education, treatment and law enforcement.

Treating Teens: A Guide to Adolescent Drug Programs *is available from Drug Strategies for $16.95. It can be ordered online at* www.drugstrategies.org *or by sending a check to Drug Strategies, 1150 Connecticut Avenue, NW, Suite 800, Washington, D.C. 20036.*

According to the National Household Survey on Drug Abuse, more than one million young people between the ages of 12 and 17 need treatment for substance abuse, with just one in ten receiving it. Each year thousands of parents come to grips with teenage substance abuse in their families and most don't know where to turn. Now help is available.

Treating Teens: A Guide to Adolescent Drug Programs brings together current research and clinical practice in the area of adolescent drug treatment to provide guidance for parents, counselors and others struggling to help a teenager overcome addiction. *Treating Teens* looks at drug abuse in the context of adolescent development and provides a framework for understanding what has been learned about effective adolescent drug treatment over the last decade. The guide underscores the need to address developmental issues when treating adolescents and provides concrete ways to assess treatment programs. It includes hotline numbers and website addresses for finding treatment in each state, as well as definitions of frequently used treatment terms.

"Establishing that a teenager has a drug problem can throw an entire family into crisis," said Mathea Falco, President of Drug Strategies. "That's the time when the family needs good information and needs it quickly. *Treating Teens* provides guidance supported by research and clinical evidence."

According to *Treating Teens*, nine elements are crucial to adolescent drug treatment.

1. Assessment and treatment matching that includes the teen and the family.
2. A comprehensive, integrated treatment approach to ensure that the program addresses all of an individual teen's treatment needs and connects adolescents and their families with an array of community services.
3. Family involvement.
4. A developmentally appropriate program to address the biological, behavioral and cognitive changes teenagers go through—and their impact on substance abuse.
5. A climate of trust, confidence and acceptance between the teen and the counselor.
6. Qualified staff who have training and experience in diverse areas, such as adolescent development, delinquency, depression, anxiety or attention deficit disorder. A low staff to client ratio can also improve treatment outcomes.
7. Staff with gender and cultural competence who understand the needs of and issues facing clients with a variety of individuating factors, and who can develop trusting relationships with those clients.
8. A process of continuing care including relapse prevention training, follow-up plans, referrals to community resources and periodic check-ups.
9. Evidence-based treatment outcomes measured by program evaluations.

The book highlights promising programs and 144 exemplary programs. A complete profile of each program, including how it incorporates the key elements of effective treatment, is available on Drug Strategies' companion website at *www.drugstrategies.org*.

Treating Teens was developed with guidance from an advisory panel of 22 nationally-recognized experts, including leading academics, clinical researchers, treatment providers and adolescent development specialists and supported by a grant from the Robert Wood Johnson Foundation.

— Most teenagers are referred to treatment through the juvenile justice system.

— Approximately 2/3 of adolescents in drug treatment have co-occurring substance abuse and mental health problems.

Source: **Treating Teens: A Guide to Adolescent Drug Programs**

Source: Join Together Online http://www.jointogether.org/sa/news/alerts/reader/0,1854,556104,00.html

Access to Mental Health Treatment for Children

By Bonnie Adee, Mental Health Ombudsman

I have been tracking concerns about children in need of mental health care since becoming the Mental Health Ombudsman in 1999. The number one problem children experience, as reported to me, is lack of access to mental health care . . . for a variety of reasons.

I recognize that thousands of Montana children *do* receive the mental health care they need. State and federally funded programs, such as Medicaid and CHIP, are essential sources of help—and Montana's public mental health system has one of the most complete children's service continuums in the nation. We invest millions of dollars in programs to treat children who have mental health needs. Even so, too many children do not get the treatment they need and lose the opportunity to experience full and lasting recovery.

The biggest barrier to children receiving mental health care is lack of coverage for the treatment they need. Montana has 5 percent more children without health insurance than the national average. According to a recent study, 17 percent of Montana children ages 0 – 18 lack insurance coverage. The rate of uninsured rises to 39 percent for those aged 19 – 25. Given the low median income in Montana, many families cannot afford to pay out-of-pocket for mental health care.

For children who *do* have health insurance, mental health coverage is usually limited to specific services. Some policies have large co-payments, deductibles, limitations on the number of days of service, and/or maximum dollar limitations applied to covered services that affect the family's ability to afford care. Montana does have a parity law, but in order for parity to apply, a child must be diagnosed with a major mental illness. Certain insurance plans are exempt from parity requirements. For some children, the mental disorder or illness is a pre-existing condition and thus not covered. About 10 percent of the calls to my office are about children with inadequate insurance coverage for the services needed.

A second barrier to treatment is the lack of availability of the services needed. This group has coverage for the needed service, usually through Medicaid, but cannot access it. For example, integrated treatment for the co-occurring disorders of mental illness and substance abuse is still hard to find in some Montana communities. It is challenging to locate services for a child with cognitive delays and serious emotional disturbance, especially if there are additional issues such as sexualized or deviant behavior. Access to child psychiatrists is very limited in our state.

Sometimes a service is not authorized. Medicaid and other insurance carriers use utilization review strategies to determine what services are needed and for how long. A parent or a provider may disagree with the determination. For example, a reviewer may not approve the continued stay for a child in a residential treatment facility when the parent and/or provider may believe that the child is not ready to come home.

Coverage of some services has been discontinued or limited due to cost containment measures. Medicaid does not reimburse for room and board for children in group homes. Access to case management has been limited. Unless a family can pay for it, a child may not receive service.

Transition from the child to the adult services adult system can result in a gap in mental health treatment. Though a child may fit the clinical eligibility criteria and rules for the children's system, criteria and rules change when the child becomes a legal adult at age 18. The child must be reassessed and, often, establish a new "history" under the new criteria. If determined eligible in the adult system, the child goes to the end of the line to await services. Continuity of care is broken and serious setbacks in mental functioning and quality of life can occur.

Bonnie Adee has served as the Governor's Mental Health Ombudsman since 1999. She has a Masters Degree in Education from Harvard University and a Masters Degree in Health Services Administration from Central Michigan University. Bonnie can be reached at 406-444-9669.

Cool Links

Forum on Child & Family Statistics
ChildStats.gov

SAMHSA's Center for Mental Health Services
www.mentalhealth.org

Mental Health: A Report of the Surgeon General
http://www.surgeongeneral.gov/Library/MentalHealth/toc.html

Systems of Care
http://www.mentalhealth.org/cmhs/ChildrensCampaign/practices.asp

Youth Risk Behavior Surveillance System
http://www.cdc.gov/nccdphp/dash/yrbs/

Child and Adolescent Mental Health:
www.nimh.nih.gov/publicat/childmenu.cfm

Promising Practices
http://cecp.air.org/promisingpractices/#2001

Co-Occurring Disorders in Youth

The primary reason people do not respond to substance abuse treatment is underlying mental illness, while the reason people do not respond to mental health treatment is because of underlying substance abuse issues.

Addressing co-occurring disorders is a critical piece in treating youth with Serious Emotional Disturbance (SED). As reported in ***Mental Health: A Report of the Surgeon General****, 41 to 65 percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance use disorder. The rates are highest in the 15- to 24-year-old age group.*

Source: http://www.surgeongeneral.gov/library/mentalhealth/home.html

Studies show that about half of all adolescents receiving mental health services have a co-occurring substance use disorder, and that as many as 75-80 percent of adolescents receiving in-patient substance abuse treatment have a coexisting mental disorder. The likelihood of drug use and dependence increases with the severity of the mental or behavioral disorder. Among adolescents with co-occurring disorders, conduct disorder and depression are the two most frequently reported to co-occur with substance abuse. Some studies have suggested that the mental disorder preceded the addictive disorder in over 80 percent of cases where there are co-occurring disorders, particularly those that develop during adolescence.

> ***"Adolescents with emotional and behavioral problems are nearly four times more likely to be dependent on alcohol or illicit substances than are other adolescents." —NAMI***

Adults with severe mental illness and substance abuse often experience more negative outcomes—such as higher rates of hospitalization, incarceration, housing instability and homelessness. They also tend to drop out of traditional out-patient treatments more often, use more services, and cost more to serve than individuals with single disorders. Many of these negative outcomes are similar for youth with co-occurring disorders. Recent research shows that youth with co-occurring disorders have worse outcomes than youth with substance abuse problems alone.

Co-occurring mental health and substance abuse problems place unique demands upon treatment programs. It is critically important to conduct a comprehensive assessment of a youth that takes cultural factors, educational level, exposure to trauma, and family strengths into account. People treating dual disorders must have extensive training in both. Effective interventions must be related to the school, peer and family systems where adolescents routinely socialize and receive reinforcement for their behavior. Treatment options that show the best evidence of effectiveness are behavioral therapies, intensive case management, cognitive-behavioral skills training, family-oriented therapies and Multisystemic Therapy.

Because adolescents often remain in or return to the peer, family and community environments that supported and promoted their initial drug use, aftercare and relapse prevention services are vitally important.

Often people with co-occurring substance abuse and mental health disorders must receive treatment from two different sets of clinicians in parallel treatment systems. Unfortunately, people sometimes find themselves excluded from one or both systems because of the complicating features of the second disorder. Recent research has shown that integrated treatment is superior to sequential or parallel treatment. In integrated treatment, mental health and substance abuse treatments are provided by the same clinician or team of clinicians in the same program to ensure that the patient receives a coherent prescription for treatment rather than a contradictory set of messages from different providers.

Gratefully excerpted from NAMI Factsheet: *Youth with Co-occurring Mental Health and Substance Abuse Disorders in the Juvenile Justice* System *http://www.nmha.org/children/justjuv/co_occuring_factsheet.cfm*

Co-Occurring Disorders in Montana

Montana treatment providers have come to view co-occurring disorders as an expectation, not an exception.

Individuals with co-occurring psychiatric and substance disorders in Montana are recognized as a population that demonstrates poorer outcomes and require larger investments in resources across multiple domains, including mental health and substance abuse treatment settings, the criminal justice, healthcare, homeless shelter and/or child protective systems.

— ***As cited in the* 2002 AMDD Annual Report*, 50 percent of Montana State Hospital patients had a co-occurring substance abuse disorder; and***

— ***More than half of Montana Chemical Dependency Center patients had a co-occurring mental illness.***

Montana is working toward co-occurring capability using a "no wrong door" approach. This is not an easy task: Montana faces a number of barriers to meeting the needs of people with co-occurring disorders, not the least of which is stigma. Another barrier is the distance between services, which often means traveling hundreds of miles for treatment. This is especially true in Montana's 45 frontier counties, where there are fewer than six people per square mile.

Long range planning

In 1999, Montana's Addictive and Mental Disorders Division (AMDD) collaborated with providers, consumers, families and other stakeholders to establish a Co-occurring Disorders Task Force. This body is comprised of mental health and substance abuse professionals, providers, consumers, advocates, social service professionals and others. The Chemical Dependency Bureau serves as the lead agency. The goal of the Task Force is to develop a framework for improved integration of mental health and substance use disorder treatment for individuals with co-occurring disorders, with emphasis on better use of resources and improved access and outcomes.

Montana has begun a long-range planning process that will result in an integrated service delivery system for mental health and substance abuse services. The vision for integrated system development will be realized through the Comprehensive Continuous Integrated System of Care (CCISC) Model, which was adopted by the Task Force and AMDD in 2001. This model is based on eight best practice principles (Minkoff, 2000) that take an integrated approach to clinical treatment. The goal is to build a system of care that is welcoming, accessible, integrated, continuous, and comprehensive from the perspective of consumers and their families.

CCISC Principles

1. Dual diagnosis is the *expectation*, not the exception. This expectation has to be included in every aspect of system planning, program design, clinical procedure and clinician competency. It must be incorporated in a welcoming manner in every clinical contact.
2. The core of treatment success in any setting is the availability of empathic, hopeful treatment relationships that provide integrated treatment and coordination of care.
3. Assigning responsibility for the provision of services can be made in context with the four quadrant national consensus model for system level planning, based on the severity of the disorder.
4. Within context of any treatment relationship, care must be balanced with empathic detachment, confrontation, contracting, and opportunity for contingent learning, based on the client's individual goals and strengths. A comprehensive system of care will have a range of programs that provide this balance in different ways.
5. When mental illnesses and substance disorders coexist, each disorder should be considered primary.
6. Mental illness and substance dependence are chronic, biopsychosocial disorders that can be understood using a disease and recovery model. These disorders have parallel phases of recovery and stages of change. Treatment must be matched to the diagnosis, the phase of recovery and the stage of change.
7. Consequently, there is no one correct dual diagnosis program or intervention. Treatment must be individualized at a variety of levels.
8. Outcomes must be also individualized and may include harm reduction, movement through stages of change, improvement in disease management skills and adherence to treatment.

Survey of Montana's Homeless

In a 2003 survey of the homeless, the Montana Continuum of Care Coalition reached 2,658 people, of whom:

- *— 53 percent were alone and*
- *— 47 percent were heads of households with families.*

Among those who were alone:

- *— 27% reported needing drug or alcohol treatment; and*
- *— 29% percent reported needing mental health care or medication.*

Additionally:

- *— 27% said that drugs **or** alcohol;*
- *— 13% said that drugs **and** alcohol; and*
- *— 34% said that mental health issues contributed to their homelessness.*

The Intergovernmental Human Services Bureau of the Human & Community Services Division of DPHHS sponsors the point-in-time survey annually.

All Nations Youth Group

By Marian Scofield, Urban Indian Health Board

All Nations Youth Group, 2003

Many Native American youth lack the cultural ties that give them ownership relative to who they are and why they should be proud of their heritage. The Urban Indian Health Board, a small nonprofit program in Billings, offers a variety of culturally sensitive services to Native American people in the Billings area. These services help re-establish pride in heritage.

The All Nations Youth Group is comprised of Native American adolescents from the Billings area who are between the ages of 13–17. During the school year, this group meets weekly. The Medicine Wheel concept for attaining balance in the development of the individual's emotional, physical, intellectual and spiritual selves is used by this group. During their time together, they talk about issues related to adolescence and learn traditional work such as beading and drumstick making. They also learn to sing with the drum. Elmer Blackbird, a traditional Native American veteran, volunteers his time to come in and teach the crafts and singing.

For the past several years, Marian Scofield and the All Nations Youth Group (ANYG) have enjoyed annual camping expeditions to destinations that have included Native American youth leadership camps at Bitterroot Lake in Marion, Georgetown Lake in Anaconda, and St. Labre School in Ashland, Montana. They have enjoyed camping trips to significant Native American historical sites. Two recent trips included camping and hiking to the Medicine Wheel in the Big Horn Mountains of Wyoming, with stops at the Ice Caves and Medicine Rock in the Pryor Mountains, followed by a trip to South Dakota. At each stop, the youth learned the cultural significance of the site and had the opportunity to make offerings to the Creator or Higher Power of their choice.

This year, 13 young members of the All Nations Youth Group traveled to South Dakota, where they hiked up Bear Butte, a significant Native American spiritual fasting site for the Cheyenne and Sioux tribes. The group camped out at Bear Butte for one night and from there went into the Custer National Park to camp for two more days and nights. While there, they toured the Black Hills with sightseeing to Crazy Horse Memorial and Mount Rushmore. During nature walks, youth learned of medicinal herbs. Some tried their luck at fishing and swimming, and a few of the youth—along with one adult—experienced the effects of Poison Ivy firsthand!

Our last cultural happening on the trip was a walk around Devil's Tower in Wyoming, where everyone learned of the spiritual influence of this geological formation. Many Native Americans accept it as a place of spirituality and use it for fasting and vision seeking. The non-Indian people use it to hone their rock climbing skills, but the cultures appeared to work in harmony with one another.

In camp: All Nations Youth Group, 2003

The ANYG also hosts an annual poster contest workshop, which attracts submission of 800-1,000 posters from Montana and Wyoming. The annual March Poster Contest Workshop and Awards Banquet is attended by 300-500 Native American students and adults. This is the 14th year in offering this contest/workshop for the prevention of drug and alcohol abuse, HIV/AIDS, family violence and drinking and driving.

For more information, contact Marian Scofield at the Urban Indian Health Board at 406-247-7318.

The Adolescent Resource Center

By Diane Conti, LCPC, Adolescent Addictions Counselor

The Adolescent Resource Center (ARC), in Bozeman, is a non-profit organization offering alcohol and drug treatment to youth up to age 18. The Center recognizes that successful treatment is a process that includes abstinence, education, willingness, insight and family support.

Treatment at our facility is tailored to individual needs and designed to facilitate personal growth and positive change. We encourage adolescents to explore what helps them remain abstinent from mood and mind-altering chemicals. The exploration takes place through individual and group counseling. At the ARC, parents are encouraged to be involved in every aspect of their child's treatment.

Treatment at ARC generally lasts 10 weeks. We work in three steps with the following components:

1) **Pre-admission**: assessment, testing, evaluations, and case management,
2) **Treatment** groups, individual/family counseling and ongoing case management
3) **Monitoring**, after care, discharge planning and referral.

A parental support group meets monthly to provide parents with the support they need through this difficult time. ARC has a strong focus on relapse prevention. Parents can play a major role in preventing relapse, which is a process that *ends* with drinking/using. Behavioral and cognitive signs are often present long before returning to drug and/or alcohol use. Parents need to be aware of the possible symptoms of adolescent chemical dependency, which may include: changes in friends, isolation, mood swings, lack of motivation or slipping grades.

Parents know their children best. *Any* major behavioral changes need to be explored. Parents can help their adolescents by remaining educated about his or her individual relapse process.

The Adolescent Resource Center is a division of Alcohol and Drug Services of Gallatin County. For more information, call 406-586-8253.

Three Factors Behind Teen Drug Use

"Parental engagement in their child's life is the best protection Mom and Dad can provide." – Joseph Califano Jr.

According to the *New York Times* (August 20, 2003), boredom, stress and the availability of extra money are three main reasons why teens use drugs.

— Children and youth aged 12–17 who are frequently bored are 50 percent more likely to get drunk, use illegal drugs or smoke.

— Teens experiencing high levels of stress are twice as likely to smoke, drink or use drugs as children with little anxiety in their lives.

— Teens with $25 or more a week in spending money are twice as likely to smoke, drink or use drugs.

— 55 percent of all children have a moderate or high risk of drug misuse.

— The average age for first use of alcohol is about 12.

— More than 5 million children (ages 12–17) say that they can purchase marijuana in an hour or less.

— Children in schools with more than 1,200 students are at a higher risk for addiction.

Source: Columbia University's *National Center on Addiction and Substance Abuse (CASA)* annual survey of children and parents.]

For more information, see CASA 2003 Teen Survey: http://www.casacolumbia.org/newsletter1457/newsletter_show.htm?doc_id=191037

If your teen has a substance abuse disorder

1. *Don't regard it as a family disgrace. Recovery is possible just as with other illnesses.*
2. *Encourage and facilitate participation in support groups during and after treatment.*
3. *Don't nag, preach, or lecture.*
4. *Don't use the "if you loved me" approach. It is like saying, "If you loved me, you would not have tuberculosis."*
5. *Establish consequences for behaviors. Don't be afraid to call upon law enforcement if teens engage in underage drinking on your premises. You can be held legally responsible for endangering minors if you do not take timely action.*
6. *Avoid threats unless you think them through carefully and definitely intend to carry them out. Idle threats only make the person with a substance abuse disorder feel you don't mean what you say.*
7. *During recovery, encourage teens to engage in after-school activities with adult supervision. If they cannot participate in sports or other extracurricular school activities, part-time employment or volunteer work can build self-esteem.*
8. *Don't expect an immediate, 100 percent recovery. Like any illness, there is a period of convalescence. There may be relapses and times of tension and resentment among family members.*
9. *Do offer love, support, and understanding during the recovery.*

Source: National Alliance for the Mentally Ill. http://web.nami.org/youth/dualdigf.htm

Thunder Child Treatment Center

By Robert F. Bragg, NCAC II, LAT

The 12 Steps

1: We admitted we were powerless over things we believed we should control, and that our lives had become unmanageable.

2: Came to believe that a power greater than ourselves could restore us to sanity.

3: Made a decision to turn our will and our lives over to the care of our Higher Power as we understood this Higher Power.

4: Made a searching and fearless moral inventory of ourselves.

5: Admitted to our Higher Power, to ourselves, and to another human being the exact nature of our wrongs.

6: Were entirely ready to have our Higher Power remove all these defects of character.

7: Humbly asked our Higher Power to remove our shortcomings.

8: Made a list of all the people we had harmed, and became willing to make amends to them all.

9: Made direct amends to such people wherever possible, except when to do so would injure them or others.

10: Continued to take personal inventory and when we were wrong, promptly admitted it.

11: Sought through prayer and meditation to improve our conscious contact with our Higher Power as we understood this Higher Power, praying only for knowledge of this Higher Power's will for us and the power to carry that out.

12: Having had a spiritual awakening as a result of these Steps, we tried to carry this message to other people who feel stuck; and to practice these principles in all our affairs.

The philosophy of treatment at Thunder Child Treatment Center does not parallel the cognitive behavioral approach utilized in many treatment centers today. It does not rely solely upon the well-known Hazleton or 12-Step approaches to help addicts and alcoholics achieve a state of balance. Our philosophy is one that utilizes the best practices of traditional Native American culture, the Red Road Path to Recovery, along with sound therapeutic principles of addictions and mental health therapy. We *educate*, *stimulate* and help people *formulate* their own recovery plans.

The mainstays of our treatment approach follow:

1. *Compassion for the individual*, coupled with treating each person with dignity and respect, simply because each human being deserves it.
2. *Honoring of the trauma.* Every person coming into our treatment setting is wounded. They may have caused trauma to others, but they have suffered greatly and been traumatized by the disease of addiction, the dysfunction in families, and from prejudicial dominant culture abuses.
3. *Spirituality.* Each person coming to treatment benefits from our cultural, contemporary and traditional approach to Native American healing. The Creator is for all, not just the chosen few. Each person finds his or her own path and is supported in doing so through sweat lodge ceremonies, singing, smudging, talking circles, prayer breakfasts and time for solitude.

We believe that addicts and alcoholics have had spiritual crises in their lives and that treatment is a time of healing mind, body and spirit. All people are allowed the dignity of calling their spirits back in a way that satisfies their cultural and traditional beliefs. This may include talking and praying with a traditional healer or medicine person from one of our neighboring tribes. It could include creative expression through arts and crafts, writing or dance. It might mean time alone in prayer and thought. We believe each person comes in contact with

the Creator differently, and should have the right to do so.

We utilize numbered steps therapeutically in the following form, loosely predicated on the first five steps of Alcoholics Anonymous.

Step One: *We admitted we were powerless over our drugs and alcohol and could not manage our lives while drinking and using.*

We begin this step with an autobiography to seek out habits and behavioral patterns that have gotten in the way. Through the personal stories of recovering addicts, we recognize the mistaken notions of false pride, shame, denial and egotism that commonly prevent us from accepting that we are powerless over alcohol and other drugs. The powerful honest and moving testimony helps us to understand what is meant by unmanageability, hitting bottom and humility. We can't help but recognize ourselves in the beliefs and behaviors revealed by those in treatment as we witness their transformation from denial to acceptance. Although the men and women in treatment represent different economic social and ethnic backgrounds, their similarities are more evident than their differences.

Step Two: *We came to believe that a Higher Power of our understanding could help us become rational and sane in our thinking once more.*

Many addicted people have difficulty with the Second Step. We may mistake the emphasis on spirituality for a call to religion, resent the implication of insanity, or have difficulty coming back to a Higher Power. Treatment includes interviews with

Continued on Page 17

Thunder Child Treatment Center

Continued from Page 16

recovering addicts and tackles common barriers to recovery. "Insanity" does not mean mental illness, but refers to losses associated with obsession for drugs and alcohol that take us away from traditional values. "Spirituality" is defined as what is good in life. The Higher Power's purpose as explained in treatment is to connect each of us to our own spirituality. Individual testimony reveals the wide range of entities that can serve as Higher Powers and the relief and sanity that come from no longer fighting the illness alone. The word "We" becomes paramount to the concept of "I."

Step Three: *Made a decision to return to the beliefs of my people and trust in those beliefs as a way of life.*

It's one thing to tell people to "turn it over." It's quite another to offer practical advice as to how to do so. Treatment does that. The stories of recovering people from all walks of life make the abstract concepts of the Third Step accessible to those new to the program. Included are specific examples of *letting go*—of the difference between Creator's will and our own self-will as well as an examination of the concepts of trust, forgiveness, faith, patience, humility and tolerance. Living a spiritual life as experienced by the people in treatment requires reframing patterns and accepting the beliefs we chose to turn our backs on. The rewards of doing so are courage, contentment, security and serenity.

Step Four: *We identified the character defects and secrets in our lives that continued to cause us to do harm to ourselves, our families, friends and society. We wrote these on paper so we could identify the patterns that caused our problems and be rid of them. We made decisions about our behaviors that would need to change to live a good life free from alcohol and drugs.*

Abstaining from alcohol and drugs keeps the body clean. To maintain spiritual health, recovering addicts must also free their minds and hearts from the secrets that burden them. In treatment, the Fourth Step process is explained by other recovering addicts. It begins by exploring why it's necessary to do an inventory. Men and women in treatment openly discuss the fears they had to overcome before taking the Fourth Step: the fear of painful memories of being judged, abandoned and betrayed. They speak of the importance of trusting one's Higher Power and the group process. Elders are often sought out at this point. Clients gain courage from the testimony of their peers, and come to understand that no one is unique in his or her pain. Treatment makes the task of honest disclosure less painful for all.

Step Five: *We shared our Fourth Step pain and misery with the Creator and a Fifth Step listener in an honest and truthful way so that we did not have to carry our burden alone and could begin the process of self forgiveness.*

The Fifth Step is a purification ceremony during which each client goes through a process of sharing and giving their secrets, hurts, pains and vulnerabilities, in confidence, to someone who is understanding, compassionate and sincere. Not even our counselors know what is in each person's personal Fifth Step.

These steps, along with other traditional and culturally appropriate activities make up the bulk of our treatment process. In reality, though, the main work of treatment is done within the heart of each person who comes to Thunder Child. Hopes, dreams and goals are shared along with pain, fears and hurts. This allows those in recovery to become whole again and to begin their journeys anew.

The Thunder Child Treatment Center was established in 1971, and is located outside Sheridan, Wyoming in the countryside on 500 acres, with a panoramic view of the Big Horn Mountains. It is affiliated with the Intertribal Addiction Recovery Organization, Inc. This facility provides residential drug and alcohol treatment for adults. For more information, call (307) 750-2255, or visit them on the Web at http://www.thundercenter.qpg.com/

YELLOWSTONE Boys and Girls Ranch

YBGR

Yellowstone Boys and Girls Ranch (YBGR) provides treatment services for emotionally disturbed youth ages 6-18, including youth with co-occurring illnesses. Approximately 50-60 percent of youth admitted to YBGR have some type of chemical dependency issues, whether they are coming from an addiction-based family or dealing with their own substance use.

Long-term treatment for adolescents with drug and alcohol problems seems to provide the best results. Youth admitted to the YBGR Chemical Dependency program enter at Level I, where they begin to recognize their use as a problem. They progress to Level II, where they begin to understand addiction and its related pathology and, finally, to Level III, where they begin to demonstrate recovery skills.

For more information, visit YBGR on the web at www.ybgr.org *or call 800-726-6755.*

The Truancy Center Project

By Mona Sumner, Chief Operating Officer, Rimrock Foundation

Kids often regard school suspensions as play days, particularly when their parents are working. In recognition of this fact, the Truancy Center was founded in Billings about four years ago. It provides district-wide service for all area schools, and the concepts in use are research based. Children suspended from School District II for rule infractions are required to attend the Truancy Center. Parents accompany the child, where they meet with Director Jeff Hanser, a certified school counselor.

As noted in the last issue of the *Prevention Connection*, Rimrock has been experiencing significant success with the pilot Truancy Project in operation at District II, which provides chemical dependency assessments for students referred to the Truancy Center after being suspended from school for infractions involving alcohol and/or drugs. In the last issue, we discussed the assessment process used in the pilot project (see *The Challenge of Adolescent Treatment*, Fall 2003, page 10). Funding for the assessments was provided by the Chemical Dependency Bureau of the Addictive and Mental Disorders Division.

Of the 2,000+ referrals to the Truancy Center last year, 168 had infractions involving alcohol or drugs. These were the kids targeted for the pilot assessment program. The referring principal provided parents with written information on the project. Parents have been relieved and grateful for the evaluation and for the help and support offered. (In fact, of those approached, only two declined. Interestingly, both asked their children if they "wanted" to do this, then allowed the child to opt out.)

We guarantee confidentiality and make sure parents understand that the child's records are not only confidential, but the property of the treatment providers rather than of the schools. The final session of the evaluation is held with the child and parents. During this session, in addition to thoroughly explaining findings and recommendations, considerable time is spent talking to parents about why they might want to adopt zero-tolerance parenting practices and how to initiate those practices. Finally, parents and their children sign "no use" contracts.

It takes more than just a contract. We talk about the impact of substances on the adolescent brain, the realities of marijuana use and the myths surrounding adolescent substance abuse. We provide a 90-day follow-up session to see how things are going and to offer additional help as needed.

The Truancy Project became operational in mid-February. Following are data that we have collected to date on participants:

— Total number of referrals: 33

— Number of refusals: 2

— Male: 25 (78%)

— Average age: 14.76

— Average grade level: 8.8 years

— Average # of discipline referrals/child during current year: 11.3

— Disposition:

- No treatment of any kind: 3
- In-patient treatment (CD): 9
- Out-patient treatment (CD): 11
- Referral for psychiatric services: 2
- No use contract only: 3
- Parental referrals for treatment: 2
- Still being processed: 3
- GPAs below 1.0: 13
- 20 or more disciplinary referrals this year: 7.

Clearly, this program reaches kids who truly need services. Unfortunately, this may just be the tip of the iceberg. The goal of the pilot program is to demonstrate the value of a student assistance program to District II, and to promote the integration of such a program into the system. If we continue to obtain these results, we will likely achieve our goal.

Mona L. Sumner, ACATA, MHA is the Chief Operating Officer and Clinical Director for Rimrock Foundation. For more information, visit www.Rimrock.org, call 406- 248-3175 or 1-800-227-3953.

Links: Tobacco and Marijuana

A 50 percent reduction in the number of teens who smoke cigarettes can cut marijuana use by 16 to 28 percent, according to a new report by the American Legacy Foundation and the National Center on Addiction and Substance Abuse (CASA) at Columbia University (September 2003). The findings are based on a survey of 1,987 teens aged 12 to 17 and show a troubling connection between teens who smoke cigarettes and marijuana use.

According to the report, 60 percent of repeat marijuana users smoked cigarettes first. Teens who smoke cigarettes are 14 times likelier than their counterparts who have never smoked to try marijuana, 6 times likelier to be able to buy marijuana in an hour or less and 18 times likelier to say most of their friends smoke marijuana.

Source: American Legacy Foundation/CASA Report: Reducing Teen Smoking Can Cut Marijuana Use Significantly

http://www.casacolumbia.org/newsletter1457/newsletter_show.htm?doc_id=193264

Project SUCCESS

By Marianne Moon, Director of Safe Schools, Missoula County Public Schools

Project SUCCESS: Schools Using Coordinated Community Efforts to Strengthen Students

Project SUCCESS is a school-based program that informs, assists and supports high school students and their families. Goals include discouraging initial use—or reducing use—of alcohol, tobacco and other drugs and enhancing the resiliency of students so that they make positive life choices. Missoula County Public Schools (MCPS) has five Project SUCCESS counselors who are trained professionals and who provide a full range of substance abuse prevention and early intervention services to MCPS students.

Project SUCCESS Counselors (PSCs) use a variety of intervention strategies, including:

— information dissemination;
— normative and preventive education;
— counseling and skills training;
— problem identification and referral;
— individual assessment;
— individual and group counseling;
— parent programs;
— community-based processes; and
— environmental approaches.

Program implementation involves administrative strategies, which provide the foundation and operation for the program components, as well as clinical strategies. These are made up of the following components:

The Prevention Education Series—An alcohol, tobacco and other drug prevention program conducted by Project SUCCESS Counselors with small groups of students.

Individual and Group Counseling—Project SUCCESS counselors conduct time-limited individual sessions and/or group counseling at school to students following participation in all Prevention Education Series and individual assessments. There are seven different counseling groups for students.

Parent Programs—Project SUCCESS includes parents as collaborative partners in prevention.

Referral—Students and parents who require treatment, more intensive counseling or other services are referred to appropriate agencies or practitioners by their Project SUCCESS counselors.

Missoula County Public Schools contracted with Turning Point Addiction Services for the counseling in the high schools. Since starting work in December 2002, these counselors have served 210 9th and 10th grade students with the prevention education series. This includes pre- and post-testing using the *American Drug and Alcohol Survey*. Sixty percent of the students surveyed answered "yes" to the question of whether this discussion of alcohol and other drugs helped them make a decision not to start using. Seventy percent of the students surveyed answered "yes" to the question of whether this discussion of alcohol and other drugs helped them make a decision to cut down on use. Of the 654 students referred to the PSCs, 22 percent were self-referrals—a surprisingly high number. Relative to individual sessions, 579 students and 32 parents participated, and 24 referrals were made to outside agencies. The top three groups for attendance were: tobacco cessation, abusers (students who recognize they have a problem with alcohol/drugs) and children of substance abusing parents.

Project SUCCESS *Plus* has two other strategies that work in conjunction with the student assistance program in the high schools. Through the Missoula Forum for Children and Youth, Missoula as a community spends time planning ways to meet service gaps in order to help create opportunities for resiliency building among students and families. One of the most gratifying aspects of this project is the great success of the true community-based coalition.

Project SUCCESS is a SAMHSA identified proven strategy to reduce alcohol abuse and is funded for three years through the Department of Education, Grants to Reduce Alcohol Abuse. The program is based on the proven prevention principals:

1) *Increasing perception of risk of harm;*
2) *Changing adolescents' norms and expectations about substance use;*
3) *Building and enhancing social and resistance skills;*
4) *Changing community norms and values regarding substance use; and*
5) *Fostering and enhancing resiliency and protective factors, especially in high-risk youth.*

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Intervention in the Great Falls Schools

By Stormy Knight, Care Program

In 1998, Great Falls Public Schools started looking at a treatment/intervention program for our high schools. The original target group included students who'd had an on-campus infraction with drugs and/or alcohol during the school day or during school-sponsored activities. School policy calls for ten days of out-of-school suspension when that occurs. We also have a ten-day absence policy, which in effect means that if a student received a citation for drugs/alcohol, they were out of school for the semester.

The Care Program was developed to help these students remain in school. In conjunction with Benefis Behavioral Health, the schools placed a certified chemical dependency counselor in the high schools. Students with drug/alcohol infractions had the option of enrolling in the program in lieu of taking out-of-school suspension. Because the mission is to provide help rather than punishment, parents have been very supportive. The Great Falls Public School District strongly supports the program because it keeps kids in school and gives them the tools to be more productive citizens.

The actual counseling program was put together by Benefis Behavioral Health. Upon entering, each student undergoes chemical dependency evaluation. This is an individualized program based upon the individual student's needs, as determined by the counselor. There is parental, school and legal (when appropriate) participation. Sessions take place during the school day on a schedule worked out between the chemical dependency counselor and the school to minimize impact to academic studies. Students who fail to complete the program assume the original consequences set by the school.

The first year, one counselor served both high schools. The second year, the program expanded to include two full-time, ten-month chemical dependency counselors. Services were also made available to enrolled students who had received a community MIP. Students who wanted help but had not had any infractions could self refer. These options expanded our client base considerably.

Evaluation is an important component of our program. We now have four years of data to work with. The number of students receiving services has increased steadily—from 31 the first year to 56, 77 and 81 last year. The program completion rate is about 70 percent. We track pre-program grades and attendance on all students and compare them with post-program performance, then continue to track these students through graduation. The results have consistently testified to the value of the program. We also track repeat offenders, which comprise about 6 percent of the total population of students completing the program.

We were fortunate to have two funding sources. We received a four-year Montana Board of Crime Control grant, and the Benefis Foundation provided the match. As with all grant-funded projects that are successful, the issue of finding ongoing funding is a challenge. This year—our fifth year—the Benefis Foundation funded he entire project, which costs just over $90,000. We are extremely grateful for their support. With the current school funding issues, it is unlikely that the District could fund this program from within.

Even so, the District believes that this program provides a valuable service to students. It is popular with parents, recognized by the courts and an asset to the school administrators when they are dealing with disciplinary issues. Most importantly, though, if students gain some tools and make some changes in the area of their drug/alcohol use, they benefit for life.

For more information, contact Stormy Knight at the Great Falls Public Schools Care Program at 406-268-6770.

PNA Data Bites

The 2002 Prevention Needs Assessment Survey revealed that:

— 19.9% of 8th graders;

— 27.4% of 10th graders; and

— 23.4% of 12th graders

were 14 or younger when they first tried marijuana.

The good news is that:

— 80% of 8th graders;

— 57.4% of 10th graders; and

— 45.3% of 12th graders

*had **not** tried marijuana.*

The Flathead Prevention Alliance

By Linda Ravicher, Coordinator, Drug Free Communities Support Grant

In early 2001, the Flathead County Prevention Alliance, a coalition of local social services agencies, community organizations and concerned individuals, submitted an application for a federal grant through the President's Office of Drug Control Policy and the Department of Justice. They were notified in November 2001 that they had received a Drug-Free Communities Support Grant. These grants, awarded in amounts of up to $100,000, are available to community coalitions making efforts to prevent youth drug and alcohol use and abuse, and require a dollar for dollar match. The Drug Free Communities Support Grant was initially awarded for one year, but can be renewed for up to five years.

We are currently in our second year of the grant, and we anticipate the approval of our continuation application for year three. Some of the accomplishments we've made since receiving the Drug Free Communities Support Grant follow.

— Created a webpage that includes information about the alliance, the grant, asset building, and links to sites offering valuable information for parents on drugs, alcohol, and tobacco. (See: *www.preventionalliance.org*)

— Developed a series of presentations on media literacy and trained high school students to deliver the presentations to their peers and to younger students throughout the valley. This group, Team Media Literacy, has made thirteen presentations on a variety of media literacy topics. This talented group has also created, developed, produced and directed a commercial that covers marijuana, social norms, and refraining from judging others. The commercial will air on the local television channel June through October.

— The Alliance, working with the Kalispell Mayor, promoted the creation of a youth council that could offer insight into the youth perspective on issues before the City Council. The Kalispell Youth Advisory Council was sworn in at the Kalispell City Council Meeting on March 17, 2003. It is comprised of 26 high school students who meet monthly to discuss City Council agenda items that impact youth.

— Workshops on asset building are offered by alliance members who have attended a three-day Search Institute training. Many trainings have been provided to diverse audiences that have included everyone from middle school classes to employees of United Way Agencies. Workshops are customized depending on the goals and objectives of the requesting groups.

For more information, contact Linda Ravicher, Drug Free Communities Support Grant Coordinator, Kalispell, Montana, 406-756-6453.

http://www.state.mt.us/prc/

The Prevention Resource Center website is jam-packed with resources and information. Visit today to sign up for the weekly Hot News, see what kind of training is coming, look for grants or check out the prevention resources available in your area. This is one website that's really worth your time.

ASSET BUILDING

The Search Institute has delineated 40 developmental assets for raising successful young people. The developmental asset framework is categorized into two groups of 20 assets each—external and internal. External assets are the positive experiences young people receive from the world around them. The categories of external assets include:

- ***Support***
- ***Empowerment***
- ***Boundaries and expectations***
- ***Constructive use of time***

Internal assets identify characteristics and behaviors that reflect positive internal growth and development. These, too, have been broken down into four broad categories:

- ***Commitment to learning***
- ***Positive values***
- ***Social competencies***
- ***Positive identity***

***For more information on the Search Institute and the 40 Developmental Assets, visit* http://www.search-institute.org/**

Honoring a Montana Hero: *Dan Anderson*

With this issue, we're honoring Dan Anderson, Administrator of the Addictive and Mental Disorders Division. Dan has held this position since December 1995, and has worked for the State of Montana since 1979. He is responsible for the management of the publicly funded systems serving people with mental illnesses and chemical dependencies throughout Montana. When he was nominated as a Montana Hero, we received a tremendous response. We'd like to express our own appreciation and admiration for Dan's unstinting efforts on behalf of Montana's prevention, mental health and chemical dependency systems.

—Vicki Turner, Director, Prevention Resource Center and Sherrie Downing, Editor.

Dan Anderson has spearheaded efforts to improve mental health services in Montana his entire career. He consolidated and upgraded institutional services and created a modern public mental health treatment facility. Dan took on the nearly impossible task of expanding mental health services in the community while still improving inpatient treatment. I don't think a day has gone by that Dan doesn't strive to meet the goals he had set for Montana's mentally ill, "job, home, friends."

—Ron Balas, Superintendent, Montana Mental Health Nursing Care Center

Dan is one of those rare people who consistently takes on the hard jobs. Whether it is getting funding to build a new State Hospital, moving funding for services from institutional placements to ones in the community, or writing a state plan to improve services to people with disabilities or substance abuse issues, he is always in the circle of decision makers. I have enjoyed working with him for the past 25 years and can think of no situation where he was not articulate, calm, thoughtful and considerate. He has always been willing to try a different way if he thought it would help people. Dan is a true professional, willing to make the hard decisions and then carry them out. I don't think very many of us would have been willing to walk in his shoes during the past 27 years. Dan has my respect, admiration and appreciation. I am proud to call him a colleague and friend.

—Gail Gray, Director, DPHHS

Dan Anderson and I began earnestly working together during the difficult days of managed care and our paths have crossed in many ways over the years. We have been able to "agree to disagree" on certain issues but more importantly, we have always agreed on the mission and vision of improving the quality of life for people in Montana. Dan is an officer and a gentleman—I appreciate his civility and his dedication. This honor is well deserved.

—Jani McCall, Executive Director of the Montana Children's Initiative

A hero is one who is fearless, intrepid, courageous, bold, daring, undaunted, and hardy. When you've been around the State as long as Dan has, you see a lot of people and a lot of ideas come and go and come and go. If you don't possess these hero-like qualities, you don't survive intact. Twenty-seven years is longer than some state employees are old. Dan has seen governors, department directors and mental health center directors come and go. He's been involved in designing and redesigning and re-redesigning services people of all ages with mental illness request and need. He's seen a huge managed care effort come and go, and a brand new structure built at Warm Springs (something I never thought I'd see). Throughout all of it, he's had to deal with contentious environments because the people involved are passionate about how best to treat people with mental illness. I've observed that Dan has not always been treated respectfully, but somehow he always lands on his feet. Throughout all of this change, Dan's been the constant, common thread in this usually under-funded, significantly needy system. Throughout all of this change, the one very human quality I have always enjoyed in Dan—and the one I always look forward to when I meet with him—is his very dry sense of humor, especially when you least expect it. I have always enjoyed working with Dan, who has helped guide Montana through a very difficult era in the mental health system.

—Maggie Bullock, Administrator, Health Policy and Services Division

Under Dan Anderson's leadership, the Addictive and Mental Disorders Division has worked wonders over the past few years, despite limited resources. Dan has taken advantage of the creative opportunities that have come along, used them wisely and always in support of the people we serve. He has also been very supportive of his staff, and I appreciated the opportunities to take the steps I felt necessary to build the Chemical Dependency system in Montana. Dan has also devoted his expertise and time to areas of finance and Medicaid, and has provided leadership statewide in order to focus attention on the needs of people with co-occurring mental illness and substance abuse disorders. It has been a privilege and a pleasure to work with Dan.

—Roland M. Mena, Executive Director, Montana Board of Crime Control

Dan Anderson: Montana Hero

Having had the privilege of knowing Dan for almost twenty years—and being married to him the last seven—I know for real that he is a hero . . . to me personally and to the Big Sky. It is said that a hero is a man of distinguished courage or ability, admired for his brave deeds and noble qualities. It takes distinguished courage and ability to do what he's done, whether facing a legislature with dwindling dollars for human services year after year or supporting me through breast cancer, surgery and recovery. Dan has been the sponsor of many brave deeds throughout his career in mental health, including the construction of the "new" state hospital and the ongoing reorganization of mental health services, to name just a couple. It also takes a brave man to teach a teenager to drive.(now that really is a hero). My daughter MacKenzie and I admire Dan for this brave deed, as well as for his superior gourmet cooking, tutoring skills and most of all, for always being there for us. Dan has many noble qualites, but my favorite is his subtle sense of humor. As Benjamin Franklin once said,"Speak little, do much." This describes Dan Anderson. Through his quiet ways, he speaks very little but is always doing much for Montana and its human services. He ***is*** *a Montana Hero.*

—Susan Bailey-Anderson, OPI

I have worked with Dan for about twenty years. He has been a driving force yet a stabilizing influence in the mental health system since he first took the job. It was been a pleasure to work with Dan and to support him in his work to improve and expand the mental health system to a level where all Montanans could feel their family or friends were receiving the highest quality of care. Dan may have begun this job with more hair than he has today, but he still has the same level of dedication to excellence that he has always had. I have always appreciated his encouragement to make good programs better.

—Ken Kleven, LCSW, ACSW

I was glad to hear that you're going to recognize Dan Anderson as a Montana Hero for the Treatment II issue of the Prevention Connection. I think that Dan Anderson is a very good administrator and is positive and good. I like what he's doing and trying. He's been standing up against all the criticism that comes his way, but in the mental health field, no one goes away "hungry."

—Boyd Roth, MMHA, Kalispell

Montanans owe a debt of gratitude to Dan Anderson. He has committed almost three decades to improving services to people in need. We appreciate the commitment, work ethic and the creativity he has shown over the years. Thanks so much for your service, Dan.

—Governor Judy Martz

It Couldn't Be Done

Edgar Guest

Somebody said that it couldn't be done,
But, he with a chuckle replied
That "maybe it couldn't," but he would be one
Who wouldn't say so till he'd tried.
So he buckled right in with the trace of a grin
On his face. If he worried he hid it.
He started to sing as he tackled the thing
That couldn't be done, and he did it.

Somebody scoffed: "Oh, you'll never do that;
At least no one has done it";
But he took off his coat and he took off his hat,
And the first thing we knew he'd begun it.
With a lift of his chin and a bit of a grin,
Without any doubting or quiddit,
He started to sing as he tackled the thing
That couldn't be done, and he did it.

There are thousands to tell you it cannot be done,
There are thousands to prophesy failure;
There are thousands to point out to you one by one,
The dangers that wait to assail you.
But just buckle it in with a bit of a grin,
Just take off your coat and go to it;
Just start to sing as you tackle the thing
That "couldn't be done," and you'll do it.

Dan Anderson has long set the tone for new and seasoned administrators looking for the best way to handle pressure. He succeeds by remaining focused on the people who need assistance, applying common sense and maintaining his sense of humor. Dan is a hero because he leads us along the high road.

—Hank Hudson, Administrator, Human and Community Services Division

Dan Anderson and I have been around long enough to remember the days before Managing Resources Montana. Over this long professional relationship with Dan, I have had the pleasure not only of learning the complexities of the mental health system, but also the pleasure of observing his keen administrative skills, sensitivity to others, acceptance of responsibility and exceptional communication skills. Perhaps the most enjoyable times I've spent with Dan included the "Duck Ears" meetings where managers tried to coordinate services between agencies, reduce "surprises," and operationalize interagency agreements. Through this time, we established cost-sharing plans, supported the development of new and innovative programs and tried to get along with each other. Dan, thank you for your willingness over the years to take risks in the establishment and maintenance of programs that we believed would serve to help Montana's children with serious emotional disturbance.

—Bob Runkel, OPI

Based on Dan Anderson's position, I thought he was going to be just another bureaucrat, heartless and deaf to our needs. But as a Consumer (of mental health and CD services), I have found he is warm, caring, and always tries to use monies wisely. His warm eyes really tell where his heart is, despite our budgetary shortfalls and constraints. He works FOR us, without any doubt!!!

—Suzanne Hopkins, NAMI Lewistown

The Last Word

By Roland M. Mena, Executive Director
Montana Board of Crime Control

One of Montana's greatest challenges is underage drinking. The 2002 Prevention Needs Assessment revealed that 44 percent of youth between the ages of 12–17 reported using alcohol; 29 percent reported engaging in binge drinking, which means five or more drinks in one setting within the past two weeks. This is a problem. We know that drinking is a precursor to the use of marijuana, and marijuana is the precursor to the use of other—and more dangerous—drugs, and the door to potential addiction.

Addiction has an incredible financial impact. According to *Shoveling Up: The Impact of Substance Abuse on State Budgets* (Columbia University, 2001), the costs of *not* treating substance abuse and addiction impact each one of us and every facet of our state system. Between medical, incarceration, foster-care, enforcement, crime, employment and other costs, we're looking at a bottom line of about $255,817,700/year—or $291.13 per capita. And yet for every dollar spent on these social costs, less than 3¢ is spent on prevention and treatment.

Montana's publicly funded treatment system relies on an alcohol earmarked tax and federal dollars. Unfortunately, these funding sources do not translate into enough resources or capacity to meet Montana's treatment needs. Access is a major issue. When an individual decides that s/he is ready for treatment, there is a very short window of opportunity before the addiction kicks in and takes over again. We need to ensure that there are mechanisms for early identification and intervention, and learn to take a balanced approach between prevention, treatment and justice.

> ***Though addiction is nearly always fatal if untreated, it is a disease and it is treatable. Treatment is a process that provides real hope.***

In order to heal, people need more than access to treatment. They need hope. That means improved economic opportunities, better education, and ensuring that all kids have opportunities for pro-social involvement and rewards, success, and an understanding of the harm involved in using drugs and alcohol. As a state, we're working hard to improve access, not only to treatment, but to protective factors for some of our highest-risk children. Through a collaborative partnership between DPHHS, AMDD and the Department of Justice as well as treatment providers and local communities, three model programs are showing great promise: Michel's Home in Billings, Carole Graham Home in Missoula and Grace Home in Great Falls. These Mothers' and Children's homes provide long-term residential treatment for addicted mothers and their children. Without intervention, these children would remain at very high risk of repeating the destructive patterns they've seen modeled by their mothers. Instead, these homes offer a way out, a better way.

I left my role as Bureau Chief of the Chemical Dependency Bureau in October. This will be my last *Last Word*, so this is what I'd like to leave you with. We have to stop investing in short-term fixes and put our money in long-term solutions that will provide long-term pay-offs. We need to invest in people, in families, in communities . . . we need to invest in hope.

—Roland

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

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MONTANA Department of Public Health & Human Services

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